### Care Coordination Form

Please use this form to tell us how we can better help your patient. You may securely return it to us by fax at 1-866-247-1150.

<table>
<thead>
<tr>
<th>To:</th>
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<td>Fax:</td>
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<td>Patient Name:</td>
<td>Phone:</td>
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<td>Patient ID/DOB:</td>
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#### Education of patient/caregiver

- [ ] Nutrition/Diet
- [ ] Comorbidity: List ______________________
- [ ] Exercise
- [ ] Complication: List ______________________
- [ ] Safety Precautions
- [ ] Patient specific risk: List ______________________
- [ ] Disease Process
- [ ] Other ______________________

#### Skills Development/Self Management

- [ ] Self infusion skills
- [ ] Blood pressure monitoring ______________________
- [ ] Home safety/Falls prevention
- [ ] DME Training: ______________________
- [ ] Monitor for sentinel symptoms
- [ ] List symptoms ______________________
- [ ] Other ______________________

#### Compliance

- [ ] Compliance with medication, treatment plan or other items. List specific issues: ______________________

#### Coordination of Services and Support

- [ ] Assist patient with appointment or benefits coordination
- [ ] Medication access
- [ ] Transportation
- [ ] Identify community-based support services

Issues: ______________________

- [ ] Assist with coordinating authorized services (specify)

  - ________RN/Home Care Services
  - ________Occupational Therapy
  - ________Durable Medical Equipment
  - ________Support Services: List ______________________

- [ ] Physical Therapy
- [ ] Speech Therapy
- [ ] Resource Specialist Services
- [ ] Other: List ______________________

#### Follow Up

- [ ] After office visit
- [ ] After hospital discharge
- [ ] Call me to discuss patient’s care
- [ ] Other

List key issues: ______________________

#### Preferred Method of Communication

- [ ] Urgent: ________Phone
- [ ] ________Pager
- [ ] ________E-mail
- [ ] Routine: ________Phone
- [ ] ________Mail
- [ ] ________Fax
- [ ] ________E-mail

Comments: ______________________

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**WARNING:** This message is intended only for the use of the individual or entity to which it is addressed, and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone at the number above. This fax has been sent from a secure location that meets the requirements of HIPAA and other applicable regulations. Returned fax transmissions will be received with an equal level of compliance. Member privacy is important to us. Our employees are trained regarding the appropriate way to handle our plan members’ private health information. Thank You.

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